REPORT OF THE COMMITTEE ON INTEGRATION OF HEALTH SERVICES

March 1967

DIRECTORATE GENERAL OF HEALTH SERVICES
NEW DELHI

REPORT OF THE COMMITTEE ON INTEGRATION OF HEALTH SERVICES

PARTICIPANTS

1. Dr. N. Jungalwalla, Additional Director General of Health Services . . . . . *Chairman.*
2. Dr. D. Bhatia, Director of Health Services, Punjab *Member.*
3. Dr. D. N. Sharma, Director of Medical & Health Services, Uttar Pradesh . . . . . *Member.*
4. Dr. (Mrs.) H. M. Sharma, Director of Public Health, Madras . . . . . *Member.*
5. Dr. C. L. Mukerjee, Director of Health Services, West Bengal . . . . . *Member.*
6. Dr. T. B. Patel, Director of Health & Medical Services, Gujarat . . . . . *Member.*
7. Dr. Ved Prakash, Hony. General Secretary, Indian Medical Association . . . . . *Member.*
8. Dr. P. R. Dutt, Asstt. Director General of Health Services . . . . . *Secretary.*

REPORT OF THE COMMITTEE ON INTEGRATION OF HEALTH SERVICES

Preamble

The eventual effectiveness of public health progress is determined by the soundness of the principles upon which its administration is based. Two of the principles derived from British experience are significant.

1. The *Magna carta* of administrative principles was enunciated by the British Ministry of Reconstruction in 1919 and led to the establishment of the Ministry of Health.

The first principle of good administration requires that when a special function is to be undertaken, it should be undertaken by one governing body for the whole community needing the service and not for different sections of the community by several governing bodies.

2. Interim Report on the Future Provision of Medical and Allied Services[1] said:

"Preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical services must be brought together in close coordination."

Integration of health services was first mooted in 1937 in India by the Central Advisory Board of health. The principles were recommended by the Health Survey and the Development Committee (1946) as a preliminary step for the delivery of comprehensive health services. This was accepted by the Central and State Governments. Implementation was, however, slow and inconsistent. While the Central Government implemented the principle, many of the States lagged behind. This was commented on by the Health Survey and Planning Committee (1961). In one of its resolutions, the Central Council of Health recommended in 1964 that a Committee of the Directors of Health Services of Gujarat, Punjab, Uttar Pradesh, and West Bengal, the Director of Public Health, Madras, and a representative of the Indian Medical Association under the chairmanship of Dr. N. Jungal-

[1] Ministry of Health (Consultative Council of Medical and Allied Services) Interim Report on the Future Provision of Medical and Allied Services, London, 1920.

walla, the Director, National Institute of Health Administration and Education, examine the various problems including those of service conditions, the elimination of private practice, etc., and submit a report to the Government of India. The Committee was fortunate to take the services of Dr. P. R. Dutt, who compiled the report, and is grateful to him for the extensive work done by him.

A questionnaire was circulated to the State Administrative Medical Officers. Replies were received from 14 states and nine centrally administered territories. The Committee met on 12-2-1965 and subsequently visited some of the States to collect further information and to study the existing organisational patterns and their merits and demerits.

2. Definition

2.1. *Integration :* It means 'putting the parts together to form the whole.' 'To integrate' is to unify, to complete (imperfect) by addition of parts, to combine (parts) into a whole. In its application to health services, it means 'a series of operations concerned in essence with the bringing together of otherwise independent administrative structures, functions and mental attitudes in such a way as to combine these into a whole.'[1] It implies the act of combining the different entities into a single whole. Integration may be said to exist when two or more organisational units are subjected to a unified direction and a single administrative control. It is a stronger term than coordination.

2.2. *Coordination :* It is the process of achieving such operational relations among differentiated and autonomous organisational entities as will ensure their optimum functional role in attaining the goals which they have in common. Coordination is an administrative method for harmonizing and adjusting the whole relation between such components in terms of their shared objectives.[2]

2.3. *Regionalisation* is the organisation of all agencies for curative medicine, public health and social services within a given geographic area, coordinated into a single system.

3. Integration in Public Health

3.1. The term 'public health' was restricted in earlier days to sanitary measures instituted against health hazards with which

[1] WHO (1965) Integration of Mass Compaign against specific diseases into general health services, Report of WHO study Group. Tech. Rep. Series No. 2,945.

[2] Pan American Sanitary Bureau, Reg. Office, WHO. Report of the Advisory Group on Health Planning, Washington, 1962.

the individual was powerless to cope and which when present one individual could adversely affect others. Following the great bacteriological and immunological discoveries of the late 19th and early 20th centuries, the concept of prevention of disease was added. Public health thus came to mean integration of sanitary sciences and medical services. The definition of public health to include social service[4] in its scope was first enunciated by C.E.A. Winslow (1920) and has since been modified as the science and art of social utilisation of scientific knowledge for medical protection by maintaining health, preventing diseases and curing disease through organised community effort.

Public health work thus expanded from its humble concern with gross environmental sanitation to add in sequence, sanitary engineering, preventive physical medical science, social science or promotive and social aspects of personal medicine. Public health thus becomes community health care. Dr. J. B. Grant denotes by this term "organised community action to maintain health, to prevent diseases due to communicable environmental or other causes; to institute measures for the early diagnosis and preventive treatment of illness; and to rehabilitate individual disabled by accident or disease to social usefulness in the community".[5] Organised community action takes into account individual and voluntary organsation's efforts. It is needless to mention that the organised community action implies also that various forms of medical and health activities be properly performed, coordinated and balanced. In other words, the system of delivery of good medical (health) care must have a unified approach under a single administrative authority. This is integration.

3.2. An integrated health service will have:

(i) a unified approach for all problems instead of a segmented approach for different problems; and

(ii) medical care of the sick and conventional public health programmes functioning under a single administrator and operated in a unified manner at all levels of hierarchy with due priority for each programme obtaining at a point of time.

---

[4]Social services are "those services provided or financially assisted by a public authority which have as their object the enhancement of the personal welfare of the individual citizen. The political Economic Planning Report on British Services (1937).

[5]Scipp. *Conrad. The Health Care for the community* selected papers of Dr. John B. Grant. Johns Hopkins Press, Baltimore, 1963, pp. 6-7.

3.3. Such an integrated health service has many advantages:

(a) The health of the total community is looked after more effectively and more economically.

(b) A basis for comprehensive health service to every family is established, which cuts the vicious circle of endlessly referring patients from place to place.

(c) A balance is maintained in the organisation for the distribution of medical care, assuming the promotion of positive, mental and physical health.

(d) A single administrator or a person responsible for a total health programme in the community has a better overall perspective and insight into the problems, solutions and the programmes. This will assure preserving and maintaining the primacy of preventive medicine. Prevention is better and cheaper than cure. At the same time prevention is complementary to cure.

3.4. Integration of health services[6] has to be considered in three major components:

(i) Health services or functions and methods of delivery or distribution of these services.

(ii) Their organisation, and

(iii) The personnel providing the services and their administration.

3.4.1. *Health Services*

A comprehensive health care in the community is possible only by a continuous and balanced provision of personal and impersonal services.

As the famous Behemian morphologist and physiologist Johannes Evangelista Purkinje wrote 150 years back, "Medicine can only achieve its ideal when it is in a position to prevent diseases and when prevention is given greater emphasis than curative care." He thought that medicine would triumph when it became public (social) and when it sets itself the target of ensuring health and physical well-being for a people under a public authority.

Parallel services, whatever may be the historical reasons, are wasteful and are primarily the result of lack of planning or bad planning. Funds available for health care purposes in developing countries allow only a low quality of service. The health

[6]The term 'health services' covers the organisation of medical and health care as well as the preventive, environmental, curative and rehabilitative services. The word 'Services' is used comprehensively in the sense both of the services afforded and their organisation and administration.

care services should be distributed on a regional basis. The concept of regionalisation, though originated in England in 1920 by Lord Dawson of Penn Report "The State Provision of Medical and Allied Services", is found at least in some components in some countries outside England. It is comprehensive in Czechoslovakia.

This concept has extended beyond the idea of a coordinated system for delivering health care services to connote continuing education of the health care profession within the area of a region and the development of the technical consciousness of the consumer public.

Theoretically, the area to be regionalised, should contain a population large enough to be self-contained in supporting the provision of all branches of health care facilities. Coordination should be effected by establishing a two-way flow of professional and administrative services between the peripheral units and the base, which should provide teaching and training facilities.

The need for regionalisation of health care services is proportional to the economic level of the country and is absolutely essential for India, where part of the health care service must be rendered on a voluntary self-help basis. This is only possible under constant professional supervision.

An Administrative district forms a convenient basis for organising local health administration. Population of district varies from 20,453 to 62,80,915 but the medium population is 1.2 million. At this level, it is easy to bring health services in closer association with development of other activities such as education, agriculture, animal husbandary, industry, irrigation, communication, etc. A district hospital also provides a base for developing specialist services in an integrated manner thus effecting economical use of specialist advice and technical equipment. Thus a district hospital should be such as to be able to serve as the basic instrument not only for providing medical care but also for providing instructions and supervision, guidance and consultation to all preventive, curative and rehabilitative care units in the district.

Not only the services but the methods of their delivery should be integrated, namely, the static at clinics and hospitals and the domiciliary at the home.

3.4.2. *Organisation*

3.4.2.1. General health services is a system of institutions responsible for carrying out health programmes of a multipurpose nature using to a large extent multipurpose health workers and seeking, as its ultimate objective, to meet the overall health needs of the community. A pyramidal structure with three clear distinct levels from the centre to the periphery has been accepted universally as a sound organisation for providing health services. The local level comprises the peripheral functioning units, the intermediate level (comprising several echelones, regional, district) provides guidance and on the spot supervision of the local level and the central level establishes standards and policies, etc. and assures unity in the general direction of the whole system.

It is needless to mention that integration of curative service with the preventive service or any other programme falling under the purview of health must have proper integration at all the three levels.

An organisation should be sufficiently fluid, flexible, and adaptable to meet changing programme needs without undue delay and friction and yet have sufficient structure and formality to provide continuity and uniformity in rendering services.

In a developing country the organisation should be, by purpose and by process, with a bias towards that section of the community which is of greater developmental importance.

No administration, particularly health, can afford to neglect the two newer aspects of the social problems of organisation, namely, 'Participative management' and 'Dynamic management'. These concepts have to be recognised and adapted into formal organisation, so that it makes allowances for employees' attitudes and beliefs, the governmental process and community values.

3.4.2.2. The most difficult problems of designing of an organisational structure is to place a legion of operating, supporting and administrative talks in rational groupings, which would result in a dynamic, flexible, efficient organisation capable of discharging present and future responsibilities in an exemplary manner.

The problem is, therefore, to arrange large functional groupings. Functions in each major unit can then be grouped into operating divisions and staff functions.

3.4.2.3. The distinction between staff and line activities and personnel should be recognised as an operating principle.

3.5.1. Staff functions are mainly three :

(a) *Administration :*

(i) budgeting and finances,

(ii) personnel administration,

(iii) logistics, and

(iv) management analysis and procedural standards.

(b) *Programme planning and analysis; and*

(c) *Health information and education.*

The staff functions are important in that they help in more effective and more efficient coordination by achieving clear lateral channels for communication, planning, problem solving and action.

Coordination is an essential integral part of administration. In essence, it is the creation of harmonious relationships among the components of an organisation so that their combined efforts produce a desired and sustained result.

Higher an institution the greater it is in need of effective coordination, for the various highly specialised programmes depend for successful operation on an intricate net-work of relationships with other governmental agencies at various levels and with various voluntary organisations.

3.5.2. *Personnel and administration :* The first essential step towards integration will be a unification of the cadre of staff from the so-called 'medical' and 'public health' side and also the specialists and teaching faculty. A reorganisation of the cadre is essential to bring all the existing cadres on a par for purposes of pay, allowances, conditions of service, promotions, and so on. Some of the aspects which deserve consideration during such reorganisation will be the interchange and transfer of clinical, preventive and teaching posts and rotation of medical officers from rural to urban and *vice versa* and plenty of scope to provide consultation, guidance and confidence to the younger groups or groups left to work in isolation.

4. Historical review of development of 'medical and health services'

4.1. *In India*

The country presents today a mosaic of diverse cultural practices with an underlying unity of belief and understanding. The cultural heritage is the legacy of not one but many civilizations and religious cults that have influenced the country from time to time. India like Egypt, Greece and Rome, has had a pride of place in the development of the Healing Arts. Our ancient lore is rich with the achievement of *Shusruta, Charaka* and others in the application of medicines (of chemical, botanical and biological origin) and naturopathic methods for the treatment and alleviation of physical ailments. There are reasons to believe that there were fairly developed medical and sanitary organisations and that there was a certain amount of coordination between them in the time of Chandra Gupta and during Bhudhist era.

Modern medical services were established in the eighteenth century by the East India Company by utilising the services of army doctors. Thus medical relief had been accepted by the State as its responsibility from the very beginning. Though there was a gradual development of preventive medicine in the British Army after the Crimean and Napolenic wars no attempt was made for disease prevention excepting vaccination against smallpox. It was only after the Royal Commission of 1859 had made their recommendations in 1863 that Sanitary Commission was appointed to study and assess the public health problems and advise the Government on the actions for the prevention of diseases for Bengal, Madras and Bombay presidencies on the basis of their reports.

By 1869, Sanitary Commissioners were appointed also for North-Western provinces and Oudh, Punjab, Central provinces whose duties were purely advisory. In 1880, a single officer was appointed for the double offices of the Director General, Indian Medical Service, and Sanitary Commissioner. On the recommendation of the Plague Commission in 1904 the office of the Sanitary Commissioner with the Government of India was separated from that of the Director General, Indian Medical Service only to be reunited again in 1912. In 1921, a Sanitary Commissioner was redesignated as Public Health Commissioner and the Sanitary Commissioner in the States as Director of Public Health. The Sanitary Department became public health department.

Though the public health department had by itself been achieving successful results in many of the programmes, lack of coordination between the curative and preventive departments had resulted in large gap in programmes like MCH, tuberculosis, venereal diseases control, etc. Realisation slowly grew among the administrative medical officers that prevention of disease was a better aim of medical work rather than relief itself and also that it was in the interest of efficiency and economy that a medical man ought to engage both in medical relief and public health work. The Central Advisory Board of Health formed in 1937, recommended that at the district level, separate directing staff should be coordinated by an administrative head. Further, the dispensary doctors must be brought more intimately into the local health picture.

In 1945, though a separate department of health was constituted at the Centre, a few other departments were also concerned with health in respect of certain groups who were connected with or employed by those departments. The Director General, Indian Medical Services and the Public Health Commissioner became the heads of the medical and health departments at the Centre.

In the provinces overall administration was in charge of a Minister responsible to the Legislature. There were separate technical heads for medical and health departments, Surgeon General or Inspector General of Prisons for the Medical department and the Directors of Public Health for the health departments. The exception was in Orissa where medical and public health departments were integrated and placed under a single officer.

Reviewing the situation existing till 1945, the Health Survey and Development Committee, popularly known as the Bhore Committee, recommended:

1. Setting up of Ministries of Health at the Centre and in the provinces;
2. Formation of a statutory Board of Health consisting of Central and Provincial Ministers of Health in order to promote mutual consultation and coordination;
3. Unification of responsibility under Ministry of Health for all health services for all groups of population;
4. Integration of curative and preventive services at the Centre and in the provinces;
5. Exchange or deputation of members of the services from Centre to State and from State to Centre and States, etc.; and

6. Unified health authority at the district level.

The Committee hoped that an integration of services would automatically occur at least in the periphery, to start with, when the primary health centre was established.

Shortly thereafter, the country became independent and adopted its own Constitution. The country became a sovereign Democratic Republic and a Union of States bound together by a provision of the Constitution which gave specific powers to States and to the Federal authority, the Central Government. However, mechanisms have been provided to forge a large measure of unity in policy-making and in its execution in the face of a clear demarcation of functions between the Centre and the States. One such mechanism was the establishment of the Central Council of Health.

The Health Survey and Planning Committee (Mudaliar Committee) 1967, reviewed the situation. The integration of the curative and preventive health services at headquarters level has come about at the Centre and States except in Madras, Andhra Pradesh, and Maharashtra. Madras and Maharashtra have accepted in principle. Medical and public health departments continue to function separately at district levels except in West Bengal and Rajasthan. The peripheral level is, however, integrated in all States.

The committee have emphasised the immediate urgency for integration of curative and preventive services at all levels and also the inclusion of public health engineers, statisticians, epidemiologists and some other experts in the Centre and State Directorates.

The Committee have recommended orientation of number of medical and public health service and periodic shifting of personnel from medical to public health posts and *vice versa* in order to make the integration process smooth.

The Committee also recommended the formation of an All India Health Service which would have on its panel specialists, consultants and teachers who can be exchanged and deployed according to the needs of the Centre and the States.

4.2. *In the world*

The system of public health of countries varies widely, depending on the historical, social and religious traditions, political conception, administrative structure, economic and social levels, awareness of the people and on the responsibility

placed by the government at 3 traditional levels, central, intermediate and local. The general trend in all countries is towards comprehensive and integrated services.

The USSR provides a good example. The State accepts the full responsibility for the provision of all health services within an integrated socialist political economy. The broad pattern is of national health system as a part of a planned economy in which·

(a) all health establishments are state-owned and supported and all health staff are state-employed;

(b) the executive effort is performed by local health units, individual and otherwise combining preventive and curative methods with emphasis on the former.

Since 1956, preventive and curative services have been integrated through the rayon hospital.

At higher levels a network of advisory councils and scientific and research institutions assists the health ministry and departments.

Czeckoslovakia is another good example.

5. Certain changing concepts in health administration

5.1. *The broadening outlook on social welfare :*

The trend relates to the closer understanding between health and social welfare with social insurance as the connecting link and a valuable piller of social welfare. This would permit health care service to evolve within the framework of social security and health insurance.

5.2. *Centralisation and decentralisation :*

Trend towards decentralisation is greater in strength, impetus and variety than any movement in the contrary direction. Decentralisation is however rarely complete because the Centre must always retain some element of ultimate control, not merely through guidance and advice but through appropriate inhibitory devices and financial nexus is almost always present. Control apart, degree of delegation varies enormously.

The general trend for the Central Government appears to retain powers relating to national health protection measures, relations with other countries on health matters, high level planning, control of financial subsidies, and highly specialised matters such as radiation protection etc.

Extremes of centralisation and decentralisation are being modified. The WHO Regional Conference on Public Health Administration in Europe (1964) concluded that there were no merits in centralisation or decentralisation in themselves as academic concepts and that the touchstone of criteria for the degree of centralisation or decentralisation must be the efficiency of the service which it brings to the patient and the community.

5.3. *Specialisation* .

Specialised services should be developed at proper levels but precautions should be taken against excessive specialisation or creation of specialisation within a specialty. Training of general practitioners in preventive medicine must be improved and also his status both with the public and with the medical profession enhanced.

5.4. *The changing concept of preventable diseases.*

The term "preventable disease" has now a wider connotation than before. This broader concept has formed the background of many of the newer preventive health services. An understanding of the causation of nutritional disorders has pointed the way to preventive measures.

5.5. *Integration of the preventive and curative care services*

There is a definite trend towards integration of preventive and curative medical care services within a comprehensive health services.

Integration is fundamental principle of public health in the USSR, where preventive and curative services are one and indivisible, with the common objective of prevention. All local health services are unified and centered in the district hospital under one administration.

5.6. *Towards better mental health*

With expanding knowledge of medical psychology and new methods of treatment a new orientation on medical health is revealing and a wide field of opportunity for the health services is opening up particularly in preventive mental services.

5.7. *Growing emphasis on health education*

The adage that "Prevention begins and ends with health education" is now being recognised and reflected in the movement to expand and develop health education work. The trend

is for health education to expand its influence as an essential preventive and health service, aided by modern techniques of presentation and specially trained personnel.

5.8. *The biostatistical approach*

A statistical service is essential for planning, administrating and evaluating health services. The epidemiological method is now being used more widely to determine the incidence, background and contributory factors of many diseases, infectious and non-infectious, and many health problems. The biostatistical approach to the solution of various health problems is widening rapidly.

5.9. *International collaboration*

The movement towards closer collaboration in health affairs between countries officially and unofficially is an important trend.

5.10. *Organisation*

5.10.1. Large scale organisations must be regarded as cross-sections of the total society. Organisation in future will put greater stress on the dignity of the individual. Equality of treatment throughout the organisation will grow in importance.

5.10.2. *Improved channels of communication and cooperation—horizontal and vertical*

Communication is the central means of combating disorganisation and lack of coordination. Tremendous advances in data processing have provided the means by which information could begin to play such a role.

5.10.3. The idea of the top executive as the real coordinator of the organisation is becoming less and less realistic. Individuals will continue to symbolise the total organisation but for coordinative requirements, the executive tends to be a group without however destroying the image of the chief executive as the individual leader of the organisation. This means that much of organisation theory which concentrates on the role of the person at the top of the pyramid, is due for substantial amendment.

5.10.4. There is a trend towards fewer levels of hierarchy and toward an expansion in the span of control of executives. This flattening is due to the conscious effort to delegate authority within the organisation. Modern devices and increased use of staff leave the executive better equipped to deal with

more subordinates than previously. The flattening puts the executives in closer touch with his organisation and hence in a position of more effective control. It is probable that flattening will continue in future organisation patterns, particularly as the dogma of the small span of control recedes as an important structuring criterion. In other words organisation pyramid is undergoing a "squeeze" which will make it in future more like a rectangle.

5.10.5. The contemporary trend in large scale organisation is towards decentralisation. This is because some organisations are incapable of controlling from the top. On the other hand, stultifying inplexibility, red tape, poor and costly service, a distorted "civil service" mentality, etc., have all forced urgent attention to decentralisation efforts. Decentralisation suggests a system in which the coordinating process will be less restrictive and in which people will have an opportunity to pursue their individual goals to the maximum and yet work in harmony toward group goals with others who look upon things differently. Local autonomy, beginning with the individual, is an important credo of decentralisation.

It is welfare-centred with a certain flavour of devotion to human uplift. It retains at the same time the production drive and competitive atmosphere of the industry. The formal structure of a decentralised organisation tends toward hierarchial flatness; specialised support to the operating levels is provided on the basis of the line and staff pattern.

It calls for a change in the pattern of executive behaviour from a stereotype to model executive behaviour. His jobs become planning, evaluation and delegation. Delegation is a real part of decentralisation philosophy. Decision making is to be pushed down to the lowest practicable level, depending on:

(a) the skill and competence available at a certain decision centre; and

(b) the amount of information that can be made available at that decision centre.

It is in the beginning a more difficult way of life because it involves a change in behaviour running counter to historically rooted cultural patterns of mankind. It not only exacts maturity and character from individual members of organisation, but also requires that they be present in the culture of the larger society.

5.10.6. The concepts of organisation have been modified in the past decade by extensive research into the social problems in organisation. Research has been mainly in 2 fields :

(a) participative management; and

(b) dynamic management. It emphasized the objectives of the organisation in relation to changing values of society, the constantly evolving governmental process of study, preparation, adoption, and modification of public policy; the influence of pressure groups, the interdependence of business and government in policy formulation and other organisational changes that occur constantly in response to a changing environment. It is here that organisation and management are most directly affected by sociology, economics, public planning, geography, political science and psychology.

5.10.7. *Other trends include :*

(a) close alignment of related functions in patterns designed to promote the attainment of specific programme objective.

(b) Research is becoming an integral part of each programme. This would need programmes in research particularly operational research and training of various levels of workers for community health service, planning and management.

(c) Programme budgeting rather than organisational budgeting is coming into vogue.

5.11. *Undesirable Trends*

5.11.1. *Fragmentation (splintering) of health services*

As the definition of 'public health' grows and public concern sharpens, a disturbing manifestation is the growing fragmentation not only of health services but also the dispersal of public health services among many agencies of government. An associated leading problem is the increasing tendency to create a special authority or commission to handle a single health problem. Although there may be some temporary advantages in this approach, the result is a splintering of a health function from an overall health problem.

This trend is also assuming importance in this country.

5.11.2. Continuation of responsibility for health of different segments of the country in organisation and ministries other than health.

6. The Present Position

6.1. *Central level*

The Director General of Health Services is since 1947 the single administrative head of both the departments of medical and health replacing the Director General, Indian Medical Service and Public Health Commissioner.

6.2. *At State headquarters*.

Integration of curative and preventive health services has been carried out at State headquarters level except in 3 states namely, Andhra Pradesh, Madras and Maharashtra which still retain the separate Directorates of the medical and public health services. However, Madras and Maharashtra have accepted the principles and the other state is likely to follow suit shortly.

6.3. *Regional level*

A regional level exists in a few States.

6.4. *At district level*

Some of the States with integrated Health Directorates are yet to integrate the district health organisations. Assam, Bihar, Kerala, Madhya Pradesh, Punjab, West Bengal and Centrally-administered territories have their district programmes controlled by a single administrator. In these States with integrated district health organisation, the Civil Surgeon, variously called as Chief Medical Officer of Health or Senior Executive Medical Officer who is usually a clinician, belonging to the "Medical Services" has assumed nominal control of 'Health' activities. The former D.H.O., who is now a Deputy to the D.M.O., or D.C.M.O. still maintains actual supervision though he has lost independent charge of public health work. In any case, his supervision is strictly limited to "public health work".

6.5. *At sub-divisional level*

The sub-divisional level is, like regional level, not a uniform level of administrative hierarchy. It exists only in the eastern States where it was introduced in olden days to meet certain administrative needs. In Assam, this level is integrated.

6.6. *At Primary Health Centre level*

Integration is stated to have been carried out at the local level in all States. However, functionally, the medical officer is interested in and keeps himself busy with his clinical work (not necessarily owing to the load of clinical work) and exercises no supervision either over MCH and family planning staff or Sanitary Inspectors and as such integration has been very slow and tardy.

6.7. *Cadre of medical personnel*

Unification of cadre of doctors has not been carried out in most of the states except in Assam, Kerala, Madhya Pradesh and West Bengal. The matter is, however, under consideration in most of the other States.

A wholly integrated service with unitary avenue of entry and unitary cadre with scope for proper placement, promotion, etc., exist in Centrally, administered territories, West Bengal, Madhya Pradesh, Assam and Kerala. Except for Pondicherry and Assam, teaching jobs in medical colleges do not find a place in the joint-cadre.

A trend is gaining ground in separating medical education from the integrated service. This is the situation in Kerala, was so in Punjab till recently, and has been implemented in Madras.

6.8. Thus, truly three patterns become evident:

1. a wholly integrated state service with unitary cadre and avenue of entry;
2. a wholly dichotomous service with 2 branches, separate right from the beginning or very nearly so; and
3. a mixed intended or proposed to be integrated but actually functioning as a dichotomous service.

In sum, partial integration has been carried out in most States either at the State Headquarters, intermediate or at the periphery.

In the matter of private practice views are widely divergent. The consensus of opinion as could be sifted from the replies does not seem to be in favour of abolition of private practice among government medical officers.

7. Discussions and Comments

7.1. The health services and health programmes in the country have during the past 15 years increased at an unprecedented scale. A fixed organisation has its inherent weakness in that it defeats its own purpose in the presence of a highly dynamic situation. Examples are in plenty where, as a result of trying to fit existing and increasing functions, some important activities have been burried too far below the level of policy formulation and decision or, the dilemma of selecting a major functional grouping for the focus of a new activity has resulted in a wrong choice. These may result in functional relationships to become blurred with resultant loss of coordination and control. Health services administration has also undergone certain evolutionary alterations but this has not been uniform all over the country. Some states have completely reorganised their administrative organisation at all levels but in most others, there has only been a certain amount of reshuffling of responsibility with the organisation. Additional steps must be taken to build up a dynamic, fluid, and flexible organisation, capable of absorbing present and future responsibilities in an efficient manner.

7.2. *At the Centre*

7.2.1. *Between the Ministries*

The responsibility of the health at the Centre has not yet been unified under one Ministry. This is not in confirmity with one of the basic principles of administration enunciated in 1918 by the British Ministry of Reconstruction, which was responsible for the creation of British Ministry of Health. "The first principle of good administration requires that when a special function is to be undertaken, it be undertaken by one governing body for the whole community needing the services, and not for different sections of the community by several governing bodies."

Health in respect of labour is the responsibility of the Ministry of Labour and Employment. The Employees State Insurance Act provides a means of coordination of efforts between the Ministry of Health and Family Planning and Ministry of Labour and Employment and the medical officers working in the Employees' State Insurance Corporation have been included in the Central Health Service. Still, there is room for further closer association so that better services can be provided

more economically by pooling of the resources to the extent possible. In the interest of efficiency and economy, it will perhaps be desirable to bring the other sections of the community within the fold of the Health Ministry. Until such time the coordination of efforts might be envisaged through Inter-Ministerial Coordination Committee.

7.2.2. *Within the Ministry of Health*

Administrative procedures are being adjusted to avoid duplication of efforts between the Director General's office and the Ministry. One of the tools devised is to have common offices and files. The Planning Bureau provides an example. Primary Health Centre Cell is another example. Another significant tool is the joint staff meeting which provides an opportunity to present more varied subordinate view-points to the Minister and the Secretary.

Under the constitution of India, the various functions in respect of health are shared by the Central and State Governments. The provision of medical relief and preventive health to the people is the responsibility of the State Governments. The Central Government's responsibility includes subjects such as international health and food quarantine, inter-state quarantine, research, promotion of special studies and administration of Central agencies and institutions.

The Centre is now directly responsible for State subjects only for the Territories of Delhi, Andaman and Nicobar Islands and Laccadive, Minicoy and Amindivi Islands.

The Centre and States have powers of legislation on certain subjects included in the concurrent list.

The Central Council of Health Zonal Councils provides the mechanism for joint consideration of the broad lines of policy for all matters of health including legislation, pattern of development in the country, etc.

In a developing country like India with so little resources, burden of health problems and administration of health care services is growing too big and too complex for either the Central or State Governments to handle efficiently alone. There are many areas the States do not have the resources to handle themselves and many more in which the Central Government must take the initiative if anything is ever to be done. There is a gradual recognition that most of the programmes need local focus and effort to make them work efficiently.

Any governmental activity is almost certain to involve the influence, if not formal administration, of all three plans of government, Central, State and Local.

The Central Government is trying to find the most effective way possible to solve the problems and share the burden. In this the Central Government have wisely resisted the temptation of playing too pervasive and domineering a role in decisions that are better made at the State level. The Central Government had been seeking the help, cooperation and counsel of the State and voluntary agencies. It is forging partnership that has wide-ranging implications. The future of the Central compact depends on the willingness and ability of the States and local bodies to help it find the way. There is now a better realisation that the programmes are joint ventures of Central Government, States and local bodies and realisation of the national responsibility in every sphere that no major activity can be undertaken in any sphere except as it works through States, cities and local bodies and private citizens.

7.2.3. *Directorate General of Health Services*

The Organisation of the Director General of Health Services has been under periodical review particularly during the last 3 or 4 years. Various common functions are being grouped into bureaux such as Central Health Education Bureau, Central Bureau of Health Intelligence, Planning Bureau, Central Public Health Engineering Organisation. Owing to the nature of the functions, the Directorate General of Health Services, will have large number of specialists and programme chiefs. Coordination between the various functioning units is a major activity. Though coordination is the responsibility of every programme chief, their activities are at present being coordinated by Additional Director General.

Now that a new Department of Family Planning has been created, the organisation is again being reviewed to bring about more effective coordination between family planning and health services and also within health services organisations.

Indications are that the community health services will grow in more and more importance as they integrate more and more the vigilance and residual activities of eradication/control programmes attaining their objectives and undertake additional load of reorganised MCH and family planning activities. It will perhaps be necessary within a foreseeable period to have separate unit under a Deputy Director General to reduce to the utmost (almost to a single channel) the professional

channel of communication by funneling of information other than routine matters to State level. These would improve the quality and the speed of actions to be taken by the State Governments.

7.2.4. *Central Regional Organisation*

Experience in this country and outside with a federal structure has indicated the need for a central health organisation on a regional basis nearer the States, with the following functions:

(a) specialised technical assistance in public health administration and generalised technical assistance in programme matters;

(b) maintenance and improvement of inter-governmental relations;

(c) programme promotion;

(d) collection of intelligence on regional health problems and programmes; and

(e) administration of grant programme.

7.3. *State level*

7.3.1. *State headquarter level*

Main functions include establishing of general standards and assuring of unity into the general direction of the whole system. As such, there will be a number of specialist units. It is necessary to group the related functions into a smaller number of units and to effect coordination between them. There must also be a clear line of demarcation of line authority and staff functions.

The advisers or programme directors at the Directorate will have to lay down norms and standards of work load and functions and also the methodology for some of the programmes other than the national programmes. They have to work these out in consultation among themselves and also with staff in the periphery. It is also equally necessary that the teachers of clinical subjects particularly of preventive and social medicine participate actively in drawing up job specifications and programme plans. The need for a combined thinking cannot be over emphasised since the plans and work schedules should not become unrealistic in the hands of any one group of persons owing to a tendency to over-look practical difficulties which the field staff would be able to present graphically.

One of the main weaknesses in the state organisation has been the lack of coordination between the various programmes and the tendency of the programme chiefs to run their programmes without due care for other programmes or the general health services. The organisation of the various State Health Directorates varies greatly, horizontally and vertically. It will be rewarding to carry out review of organisation including analysis of personnel and facilities utilisation, with the object of meeting present needs and anticipated future needs. Establishment of a separate planning cell with fostering of a positive attitude towards management and planning by encouraging participation and involvement at all levels is a crying need. Reporting, indenting, accounting and many of our routine procedures need immediate specification and standardization.

In a State Health organisation with about 20-30 units directly under the Director of Health Services, coordination through individual programme chiefs is difficult to conceive and achieve. It calls for special coordination efforts. A coordination cell unit becomes necessary. One of the main functions of this coordination unit would be to summarise the contents, interpret, comment, indicate a priority in the various actions desired by the various departments to be taken at the peripheral level. In this way, the Department will be able to maintain at a desirable level, the organisation and the programmes at the periphery, control the behaviour of the peripheral units by the control of communication and coordinate the babble of voices into one voice to develope an integrated health programme by striking a compromise among the specialists and between the specialists' view and the local views.

7.3.2. *Intermediate level (district, regional/zonal/sub-divisional*

7.3.2.1.

The main function is to provide immediate guidance and on the spot supervision to the local level. Through its responsibility for immediate supervision, it holds the key to the success or failure of any kind of health work. Since the primary health centres have to function in a regionalised framework, it is essential that integration of various functions takes place at this level. A uniform and proportional development of the services require the unified consultative efforts of the clinical, preventive and teaching branches.

Since the staff at the local level require supportive supervision in routine activities and the many special functions that can be provided only by the specialists, district organisation should be under a unitary administrative command with specialist cells for advisory functions.

In the interest of fuller utilisation of personnel and facilities, the following are essential requisites for a district administration:

1. Adequate authority and responsibility for the Medical Officer of Health in charge of the district to act with a minimum of interference from State Government or panchayati raj administration. This includes delegation of administrative and financial authority by panchayat and government to Medical Officers of Health for all personnel.
2. Removal to the fullest extent possible of routine clinical duties from Medical Officer of Health in charge to lay administration.
3. Provision of a high powered mobile team of multidisciplinary health professionals for stimulation, consultation, and supervision.
4. Integration of not only preventive, and curative (rehabilitative if present) services but also of service, education and administrative research.
5. Rationalisation of administrative organisation with separation of staff functions and line authority.

Since the administrative competence is the primary objective, chiefs of the district health organisation may be selected from either curative, preventive or teaching specialists. They must be made available for technical consultations on patients as needed. One of the most important functions, is how to make an inventory of existing resources so that they can be coordinated and expanded to meet a measured demand. If health service planning and management and preventive activities are to be given high priority, it is essential that individuals with overall administrative responsibility for the health work (Chief Medical Officers) be given training or orientation in public health particularly in the technical and administrative science of planning and management of integrated medical and health care services and also in hospital administration. Another criterion on which the Bhore Committee laid emphasis is the experience of the officer in community organisation.

The Chief Medical Officer should either have full training as of D.P.H., or a Staff College training Course at National Institute of Health Administration and Education in which the art and science of public health administration should be given greater emphasis than now.

7.3.2.3. *Regional & zonal level*

An officer of the grade of a Deputy Director will relieve the Director of Health Services greatly in routine matters, epidemiological intelligence and in carrying out investigations. There should be one officer for not more than 4 or 5 districts on the basis of work load, adequate staff should be attached to the officer.

7.3.2.3. *Sub-Divisional level*

After the District Health Organisation has developed reasonably, some of the responsibilities of regionalisation may be devolved to the sub-divisional level when more facilities will be provided at that level.

7.3.2.4. *Peripheral level (primary health centre)*

More often than not the peripheral unit referred to is the primary health centre. Except for special clinics, small hospitals, etc., the flow of services into the community will be through primary health centres. It is taken for granted from the very nature of the concept of primary health centre that the services have to be administered in an integrated manner.

Unfortunately there have been certain difficulties in the implementation of this concept. The primary health centre, to be effective, must be a paramount institution and the medical officer must provide adequate supervision and guidance, administrative and technical, to the staff. The logical chain of command would be to have direct administrative and technical channel through the Medical Officer of the primary health centre. The entire staff of the primary health centre should be under the administrative control of the medical officer in charge and it is not desirable to have a part of the staff under the direct administrative control of panchayat or the Block Development Officer.

7.4. *Unification of cadre*

7.4.1. This has been a burning question in all the States and also at the Central Government level. Barring a few States

others have not been able to achieve this yet. The Indian Medical Association has recommended that there should be uniformity in all the States and a standard pattern be evolved not only for the integration of the two Departments but also for a unified cadre with uniform remuneration of the following patterns:

Junior Scale : Rs. 625-30-775-35-950-EB-40-1350
Senior Scale : Rs. 1000-40-1200-50-1450-EB-55-2000
Selection Grade : Rs. 2000-100-2500
Special Posts (D.G./Addl. D.G./C.M.O. (Railway) : Rs. 2750-125-3000

The advantages of unification of cadre are real in that it does away with the multiplicity of cadres and with it, the so-called caste system, it creates a sense of belonging to the same family and fosters a *respirit de corps* which is an essential ingredient in Health Department where the personnel constitute the main resources.

The formation of Indian Medical and Health services is under discussion. This would include Class I officers upto Civil Surgeon and D.M.O.Hs. Since this is still under discussion, we will also have to think of a cadre for each State. Thus we require two cadres, Central and State.

7.4.2. *State cadre*

7.4.2.1 *Pay and Allowances* : At present pay and allowances of the States vary greatly. West Bengal and Punjab scales are higher than those of other States. The question of uniform scales of pay throughout the country is complex as they depend on various factors. It is probably difficult to find two countries having the same scale of pay unless the countries are related to each other through some administrative connections. What is important to ensure is that the physicians' pay and allowances should compare favourably with that of the State Civil Service Officers. However, there should be grouping or categorisation of the cadre; junior scale, senior scale and selection grade.

Physicians belong to a profession that demand round-the-clock service, no regularity of hours, hard living, etc. These would need compensation in terms of special allowances. Among the allowances that may be attached to the pay of the medical officer, non-practising allowance of reasonable amount merits consideration. To avail of the services of a doctor in a community deprives his scope for making money on a larger scale which otherwise a doctor would prefer to indulge in To give his

technical skill to the community the doctor will consider it a matter of birth-right and it may not therefore be possible to stop his practice particularly owing to the financial difficulties where adequate compensation for the loss of his practice may not be forthcoming. However, for certain posts practice should not be permitted as for example the health officer at any level, the medical officer of primary health centre and teaching and research posts.

7.4.2.2. *Recruitment and service conditions:* There should be a unitary portal of entry through the State Public Service Commission. Seniority must be common for all the posts irrespective of the Division/Department in which one is working. Ante-dates may be given for qualifications but that should be given only during the time of entering the service. The period of ante-date and the reasons for giving ante-date should be specifically laid down. But this ante-dating may not count towards seniority. It will count only towards pay and allowances. The other alternative may be the grant of advance of increments for extra qualifications. The extent should however be laid down depending on the nature and degree of qualifications.

7.4.2.3. *Promotion:* Promotion should be based on certain objective criteria service for a minimum number of years plus post-graduate training in public health administration or specialty or both to equip an officer of administrative and technical responsibility required for the higher posts as in the army.

7.4.2.4. *Teaching cadre:* It appears that there is a trend for keeping the teaching and research cadre outside the main unified cadre. There are certain advantages in this. On the other hand that would mean splitting of the cadre instead of one. The people working in the medical colleges are liable to be detached completely from the happenings in the field. The people who have been successful in their line outside the Medical Colleges cannot bring their experience in education. A person who has worked efficiently as a specialist or a civil surgeon or a health officer, if he knows that he is liable to be posted in a medical college, will tend to keep his knowledge up-to-date and when appointed, will bring the rich experience of field to education. This was a system prevalent in the old Indian Medical Service and by and large this has not worked inefficiently either in the service or in the teaching side. In fact some of the research workers and teachers had been in the service before. This practice is prevalent in at least one southern State, as far as the Professor of Preventive and Social Medicine is concerned. Another State has under consideration a scheme for interchange of staff between services and education.

7.4.3. *Process of unification*

7.4.3.1. The health service of a country is as good or as bad as the people giving the service. The whole service is literally the personnel, there being relatively little overhead expenses for machinery, tools, etc. Health work has certain characteristics which give rise to peculiar personnel problems in contrast to most businesses and industries. It is a curious mixture of public and social responsibility and service. This assumes more significance in developing countries engaged in telescoping decade's work in years. Demands on the doctor in the service are so great and compensation so unremunerative as compared to other professions that in spite of the phenomenal increase in production, fewer doctors are joining the service. Moreover, there is also a drain on the profession arising out of migration of young doctors in lure of more money, and other more facilities which mortal men aspire than at home. Improvement of service conditions is the crying need of the day not only to attract and retain personnel of the right type, which is of immediate concern but also to maintain and improve quality of entrants to the profession which is of no less concern to the society at large.

Fortunately, the political and professional leaders of the country are aware of the great importance of a unified cadre as a corrective measure. In fact, this is virtually the single measure for a great leap forward to integration. The process of unification remains a manysided problem. It is an administrative problem relating to the useful employment of different categories of doctors with various specialities, equation of posts, determination of seniority in the cadre, recruitment, compensation, tenure and promotion. It also poses psychological problems. Curative work has a greater prestige not only among the people at large but also inside the professions, apart from its financial advantage. Administration is associated with a high status but unfortunately public health, research and even teaching have neither the prestige nor the appeal. Research and teaching carry prestige to the extent the persons do private practice. Naturally, attempts at unification will be resisted. Many virtues of separate cadres will be recited. The 'public health' workers fear that they will be 'swamped' by the bigger 'medical' workers group. It is therefore of the utmost importance to remove psychological barriers.

7.4.3.2. Integration has been attempted in a few states but not uniformly. While it may not be necessary to evolve a uniform method for all the states, it is probably desirable to lay down certain norms to ensure a fair measure of uniformity.

7.4.3.2.1. We may look to the armed services which is oriented to preventive medicine. Military Medical Organisations have to solve problems of organisation, training, support, transportation, equipment, etc., much more quickly than most liesurely moving civil organisations. It would be worthwhile to explore systematically the possibilities for application to civil use. We may also draw upon a few states that have undertaken the integration.

West Bengal

Medical and public health services were brought within the fold of a unified cadre through promulgation of:

(i) West Bengal Health Services (Cadre, Pay and Allowances Rules, 1958).

(ii) West Bengal Health Services (Pay, allowances, Promotion of Non-gazetted medical officers Rules, 1959).

The former rules did away with the expression "Civil Surgeon, assistant surgeon, and sub-assistant surgeon".

Every doctor was called 'medical officer'. Particular posts would not carry specific pay scales. A medical officer would draw pay according to the grade to which he may belong irrespective of the appointments held by him until he is promoted to the next higher grade according to his seniority and suitability

The latter rule brought posts of non-gazetted medical officers within the unified cadre from 1-1-1959. The entire cadre became a non-practising cadre with the only exception that controlled private practice was allowed at the discretion of the Government to the specialists posted in district and sub-divisional headquarters hospitals on such terms and conditions as may be prescribed from time to time. Another step was the reorganisation of the existing set-up of the Directorate of Health Services including district and lower levels under which the civil surgeons were redesignated as 'Chief Medical Officer of Health' and placed in administrative charge of both the "curative" and "preventive" activities in the district, being relieved of all professional duties in district hospitals, which developed on the senior most medical officers of the district hospitals designated as the "District Medical Officers" (G.Os. No. Medh/1069878-2/57, dated 10-12-57).

Later in 1965, certain posts were declared non-practising and officers were allowed option of private practice in the exempted posts (W.B.G.O. Estt./2007/25-120, dated 1-4-65).

Particulars relating to pay scales, allowances, etc.

The general pattern is that the officers in their early career work as general duty medical officers in hospitals, health centres, public health duties, national schemes and teaching duties (Formative stage). Subsequently, depending on training, aptitude, actual performance, etc., they have the chance to chalk out their future, *i.e.*, whether to remain in public health work, clinical work, teaching or administrative (Definitive period).

Finally, a selection is made to earmark 6-10 likely candidates for the top position.

Thus it may be said that in an officer's service life there is a formative period, definitive period or mid-phase and a final period preparing for the top appointment. There is no discrimination in the pay and allowances of officers, wherever they happen to be employed, *e.g.*, teaching, clinical, administrative or public health duties. There are also three grades of service *e.g.*,

(i) Basic grade	Rs. 300 to 800
(ii) Selection grade 8%	Rs. 850 to 1,350
(iii) Special selection grade 2%	Rs. 1,500 to 1,800

with allowance, e.g., non-practising pay, public health allowance, administrative allowance, rural allowance, work allowance, etc. Details are in Appendix '3'.

7.4.3.2.3. *Punjab*

Under the reorganisation pattern (District level), the various cadres have been amalgamated and the Punjab Civil Medical Service has been renamed:

1. Punjab Medical Services I (PCMS I) Selection Grade	Rs. 1,300 to 1,600
2. Punjab Medical Services I	Rs. 750 to 1,250
3. Punjab Medical Services II	Rs. 250 to 750
4. Punjab Junior Medical Services	Selection grade Rs. 400 to 600
5. Punjab Junior Medical Services	Time scale Rs. 150 to 380

7.4.3.2.4. *Mysore*

Integration is being carried out in stages.

As a first step, medical institutions at and below taluk levels had been transferred in 1960 from the medical department to public health department. The cadre of medical and public health personnel had also been unified, while recruitment to the service and new recruits are designated as assistant medical officers of Health-*cum*-assistant surgeons since 1960.

As a second step amalgamation of services at the Directorate level had been effected since December, 1964, when the posts of Director of Medical Services and Director of Health Services were abolished and a unified Director of Health Services formed.

Complete integration of medical and public health depots at all levels has not yet been achieved by integrating service personnel of both departments.

7.4.4. *Some suggestions emerge*

1. *Recruitment:* There will be a single portal of entry for all medical officers, in curative, public health, research, training, etc.

2. *Cadre:* Cadre will be one. It may be sub-divided into 3 grades :

(a) Basic Grade ;

(b) Selection grade 20%;

(c) Special selection grade—5%.

3. *Seniority*

There should be a common seniority which automatically follows recruitment.

4. Ante-date for post-graduate qualifications at the time of entrance; the varying periods should be fixed for various qualifications. This will count towards advance in pay and allowances but not towards seniority.

5. Pay will be on the basis of years of services in respective grades.

6. Special allowances to be added for special functions such as:

(i) Specialists—M.D., M.S., (PH), D.P.H., M.P.H., etc., types of specialists—Junior specialists and senior specialists.

(ii) Research.

(iii) Teaching.

(iv) Public Health or special programmes entailing intensive and extensive field work.

(v) Administration.

(vi) Special hazard.

7. *Non-practice allowance:* All posts should be non-practising and allowance given for loss of practice should be reasonable—50% of the pay subject to the minimum of Rs. 600.

If, however, state government wishes to eliminate private practice on a phased basis, the teaching (clinical and non-clinical subjects) and research posts, health officers at all levels (MOS, PHC included) posts, posts in special programmes (national or state) and the posts in district headquarters (administrative) and State Directorate should be brought first into non-practising group. Teachers may, however, be allowed controlled practice for not more than 2 hours in sort of paying clinics at the medical institution OPD. No option should be given to medical officers whether to practise or not.

8. *Training and orientation*

8.1. For the first 8 years medical officers will be in formative stage and be regarded as general duty medical officer. They may qualify for junior specialists on post-graduate training and get specialists' pay, if working against a specialist post. Since they have to work in integrated health care all medical officers, immediately after being recruited should undergo regular training at a recognised orientation training centre or institution in government procedures and basic principles of hygiene, health education and community organisation. This training should be for 4 to 6 weeks.

8.2. At the end of 8 years all officers aspiring to the selection grade must undergo staff training course for a period of 6-12 months. All medical officers of health and Assistant, Deputy, and Joint Directors must attend a staff course where the art and science of public health administration should be a core subject. They may be exempted if they had attended a course of DPH. Other medical officers should undergo post-graduate studies in their clinical subjects. A period beyond 12 months should be treated as study leave upto the maximum period of two years.

8.3. Medical officers wishing to do post-graduate study before 8 years may do under normal study leave.

8.4. Study leave should be liberalised.

At present facilities provided to serving medical officers for further studies are not sufficient. This is rather unfortunate since a doctor, by nature of his profession and work is a student

throughout his life. Also facilities should be provided including hostel accommodation for families during the period of study. Staff colleges, either on state basis or preferably on a regional basis, should be centrally assisted.

9. *Pay and Allowances*

Fixation of pay scale should depend on a number of factors including payment for comparable work elsewhere, cost of living, wage trends, etc. Minimum rate of a higher position should not be less than the maximum rate of lower class. The intermediate steps (between the minimum and maximum should be reasonable, say about 10 or 12).

10. Shortage of medical officers in rural areas is chronic, but not absolute; it is relative. It is an administrative problem. It is a problem not peculiar to India. Doctors assigned to rural areas must have total emoluments more than their city colleagues because of the heavier responsibilities and the less agreeable working conditions. This has been realised in many countries, socialist or otherwise. In addition to financial incentives, professional and social isolation of rural doctors (and their wives and children) should be ameliorated as much as possible by such means as refresher courses, provision of books and magazines, clinical meetings at district hospitals, etc.

7.5. It is obvious that difficulties in integrating health services may be grouped in 3 categories:

(a) administrative;

(b) psychological, and

(c) lack of orientation in preventive medicine.

7.5.1. *Administrative:* Dearth of medical officers on public health side is due to lack of aptitude and proper incentive. The cadre on the public health side has not been made as attractive as on the clinical side financially as well as from the work point of view. Having started the health officers on lower scales of pay the upgrading of these posts and amalgamating them with clinical posts is in itself a big financial problem which the government finds it difficult to handle.

7.5.2. *Psychological:* Specialisation has improved the skills and disciplines while at the same time has hampered unified thinking. This is not surprising. Specialisation breeds parochialism. Specialists do not generally like to look beyond their own branch or department and hence coordination becomes an effort.

The need and ability for synthesis and bringing about harmony between various kinds of specialised learning and functions is therefore of paramount importance.

Morever, a health officer is not looked upon by the clinicians and teachers as a person doing anything useful or as knowing enough of medicine. Even a Civil Surgeon or D.M.O. thinks very little of his counterpart, the D.H.O. on the preventive side. The Civil Surgeon is paid much better and has a senior status. The attitude of the teachers in medical colleges is no less presumptuous. Under such conditions an amalgamation of the cadres and the services appears to be a ticklish problem. This psychological barrier has to be tackled tactfully so that personalities are not affected.

7.5.3. *Lack of orientation in preventive medicine*

This is, in fact, the main reason. The idea of a community and how a comprehensive health care can be given and the economics of such an integrated service have not been considered in true light by those engaged in the curative service or teaching or research. Agreement on the principle of integration of the services has frequently been expressed in many circles but how far that is unequivocal and without any kind of reservation is yet to be ascertained. Unless a proper orientation is attempted to help the medical officers in any branch or specialty to understand the oneness of purpose in a health administration and the need for a unified approach to the problem will continue for ever. Before, therefore, establishing an integrated service the training of the doctors at different levels and in different administrative capacities is essential to enable them to fall in line with the avowed thought and objective. The integration of training, service and research should become a simple rule of three and not a forced issue. It should be a process of logical evolution and not a revolution.

7.6. *Private Practice*

The question of private practice is linked up with the total income a doctor should have. He should earn enough to give children the best education he can, and to make a reasonable living. It is bad for a doctor to suffer from financial anxiety as it makes it difficult for him to be a good doctor. It is also bad for a doctor to become rich, for the same reason. To make a fortune out of a vocation dedicated to the relief of suffering seems to be contradiction. Medicine is not a business. However, professions including medicine have the supreme merit of

opening their doors to talents from all strata of society. It is a way of bringing up the gifted to the top of a society which would otherwise stagnate in a fixed hierarchy. This would need reconsideration of criteria for fixation of pay and allowances. A physician, irrespective of whether he is engaged in clinical work or administration, supervision or research, in government service, is a real round-the-clock official. His emoluments should compare not unfavourably with other technical and administrative service officers.

It appears that many of the States are in favour of stoppage of private practice but financial insufficiency appears to stand in the way. However, a start may be made with the health officer, public health care doctors, the doctor in-charge teaching and research institutions where any inclination to make money will adversely affect the efficiency of the work and ultimately the objectives of the institute.

Certification of sickness or filling fitness, insurance medical certificates, etc., will constitute normal duties of a medical officer especially when he is posted in a rural area and hence should neither be prohibited nor considered as private practice.

8. Recommendations

8.1. *Integration*.

The Integration Committee

1. Noting the advantages of integration of curative and preventive health services;

2. Considering that the reason of non-integration of the services which are mainly administrative and psychological are neither formidable nor insurmountable;

Recommends that the States should reorganise their health services in such a manner that integration of curative and preventive services including the research and teaching departments cadres is effected.

8.2. *The Committee*

Realising that integration of services alone will not be effective unless all medical officers are brought in one cadre.

Recommends that (i) unification of cadre should be immediately effected and (ii) terms and conditions of service should provide :

(a) uniform scales of pay;

(b) drawal of pay according to the grade to which he may belong irrespective of the appointment;

(c) inter-change and rotation of officers between clinical, public health, teaching and research branches;

(d) a common seniority;

(e) chances of promotion on an overall consideration of years of service, merit, administrative capability, etc.

(f) special allowances for specialists and for special programmes and administration;

(g) orientation training, post-graduate studies and staff courses for medical officers;

(h) adequate financial and other incentives to medical officers posted in rural areas or areas declared by the state as attended with any special hazard or risk.

8.3. *The Committee*

1. Recognising that private practice deprives a medical officer of giving full attention to the work he is assigned to;

2. Noting the difficulties, administrative and financial, in eliminating immediately private practice among the medical officers in service;

Recommends that (i) private practice be eliminated on a gradually increasing phase, beginning with teaching, research and supervisory posts in the Health Directorate, Regional and District health organisation, special programmes, health officers and health centre doctors.

(ii) non-practice allowance should be a realistic and reasonable compensation for loss of private practice.

SUMMARY

1. The Central Council of Health, in its meeting in 1964, recommended the constitution of a committee to examine the various problems including those of service conditions, elimination of private practice and submit the report to the Government of India.

A questionnaire was prepared and circulated to the States. The Committee met and also visited some of the States.

2. For the purpose of this report, the committee defined integrated health services as:

(i) a service with a unified approach for all problems instead of a segmented approach for different problems; and

(ii) medical care of the sick and conventional public health programmes functioning under a single administrator and operating in a unified manner at all levels of hierarchy with due priority for each programme obtaining at a point of time.

Advantages of an integrated health service are many. The health of the community is looked after more effectively and economically than otherwise. A basis for comprehensive health care for every family is established; the single administrator has a better overall perspective and insight into problems, solutions and programmes and strengthens health administration competitively among all governmental agencies. Prevention avoid unnecessary illness, it is cheaper than cure and also complementary to cure.

3. Parallel services are wasteful and are primarily the result of lack of planning or bad planning. Health care services should not only be integrated but distributed on regional basis. The concept of regionalisation has extended beyond the idea of coordinated system for delivering health care services to connote continuing education of health care profession and the development of the technical consciousness of the consumer public. An administrative district forms a convenient basis for organising local health administration.

Health administration, like all administrations, is a means to an end, not an end in itself. Though only a tool, it is an essential tool. The test of good health administration must be pragmatic.

4. *Historical Review*

There are historical reasons for the diarchy which existed in medical and public health departments. In the early days of development of modern medicine in India disease prevention was scarcely attempted except in the case of vaccination against smallpox. Medical effort was concentrated on the establishment of hospitals and dispensaries for treatment of the sick.

When public health began to receive its due share of attention, the physicians and surgeons were already strongly entrenched and public health workers found it difficult to awaken any enthusiasm for preventive medicine among the administrative medical officers who were interested in their own specialties. It was, therefore, necessary for the public health workers to put up a vigorous fight to secure autonomy and generally speaking, the result has been an undesirable cleavage between the medical relief and public health.

However, it was soon realised that prevention of disease was a better aim of medical work rather than relief itself and also that it was in the interest of efficiency and economy that medical men are to engage both in medical relief and public health work. The Health Survey and Development Committee recommended integration as preliminary step towards comprehensive health care services. It was re-emphasised by Health Survey and Planning Committee.

5. The Health Services in the world show an unmistakable evidence of trend towards comprehensive and integrated services. There were certain trends, which justify their recognition as the background against which future progress in the public health services is likely to take place. They are:

1. Broadening of the outlook on social welfare and closer relation between health and social welfare.

2. There are no merits in centralisation or decentralisation in themselves as academic concepts and the criteria for the degree of centralisation or decentralisation must be the efficiency of the service.

3. Specialisation: specialised services should be developed at proper levels, but excessive specialisation or creation of specialisation within a specialty should be guarded against to avoid compartmentalism.

4. Changing concept of preventable disease: Application of epidemiological methods (natural levels of application of preventive medicine for a disease) to conditions other than the strictly communicable diseases.

5. Integration of preventive and curative services: Integration is a fundamental principle of public health. Preventive and curative services are one and indivisible with the common objective of prevention.

6. Better mental health: A fresh orientation on mental health is promising a wide field of opportunity in the prevention of mental disease as a part of the public health services.

7. Health Education : The indispensable role of health education in health programmes is being recognised more and more with the result that emphasis is placed for extension and development of health education.

8. Biostatistical approach: Biostatistical approach to the solution of various health problems is widening rapidly.

9. Coordination of service contributions in its varied spheres of action towards the total national health effort.

10. International collaboration and inter-dependence.

11. *Organisation*

(a) Organisation will in future put greater stress on the dignity of the individual.
(b) Improved channels of communications and cooperation.
(c) A trend towards fewer levels of hierarchy and an expansion in the span of control of executives.
(d) Participative management and dynamic management.
(e) Programme budgeting rather than organisational budgeting.
(f) Research as an integral part of each programme.

The committee also noted emergence of undesirable trends of fragmentation and a tendency to create a special authority or commission to handle a single problem.

6. The present position

6.1. Central Level: Directorate General of Health Services has been integrated in August, 1947.

6.2. State level: Integration has been carried out in all state health headquarters except in Andhra Pradesh, and Maharashtra. They are likely to follow suit shortly. Madras has issued orders.

6.3. Regional level: Regional level health administration does not exist in all states.

6.4. District level: Some of the states with integrated health directorate are yet to integrate district health organisation.

6.5. At sub-divisional level: It is only an effective level of administrative hierarchy in one state.

6.6. Primary Health Centre level: Integration is said to have been carried out in all states. However, functional integration is still incomplete to a large extent.

6.7. Unification of cadre of doctors has not been carried out except in Assam, Kerala, Madhya Pradesh and West Bengal. The trend is gaining ground in separating teaching from integrated service. In the matter of private practice, views are widely divergent.

7. Health services have greatly increased but fewer doctors are joining the service in spite of phenomenal increase in the number of doctors every year. Improvement of service conditions is the crying need of the day not only to attract and retain personnel of the right type but also to maintain and improve quality of entrants to the profession. The unified cadre is considered the single most important step towards integration. The concept of unification of cadre is easily understood but the translation of the idea into reality poses some difficulties. The first desederatum is a psychological one, namely, allay of the fear among public health doctors that they will be "swamped" by the bigger medical group. Then there are administrative problems concerned with classification and fixation of seniority. Orientation in public health will ease integration and help the staff to fall in line with the avowed objective and thought of integrated service. Integration should be a process of logical evolution rather than revolution.

While it may not be necessary to evolve a uniform method for all the states, certain norms will be of help to ensure a fair measure of uniformity. Armed Forces, West Bengal, Punjab and Mysore provide some guidance.

8. *Recommendations*

The Committee noted the tendency to retain organisational structure we had inherited. A fixed organisation has its inherent weakness in that it defeats its own purpose in the presence of a dynamic situation. Some states have reorganised their administrative organisations. Additional steps are necessary to build up a dynamic, fluid and flexible organisation, capable of absorbing present and future responsibilities in an efficient manner. In the reorganisation recent trends should be taken into consideration.

The Committee discussed the various aspects of integration and is firmly of the opinion that services should be integrated right from the highest to the lowest level in service, organisation and personnel. Responsibilities for health of different sections of the community should be unified in one authority at Central and State levels and medical education be integrated with service. The Committee also felt that in developing countries like India, entire health services have to be re-organised. The administration should be more scientifically guided.

The Committee noted that there is greater realisation of inter-independence between Central, State and local governments in health matters including the programmes.

The Committee recommended that the district level should be strengthened sufficiently to undertake comprehensive health work on regionalised basis. The heads of district health organisation may be from curative, preventive or teaching specialty, but they must have sufficient re-orientation or training in complicated technical and administrative science of planning and management of integrated medical and health care services so as to provide intelligent educative supervision and guidance in both fields. They should also have experience in community organisation.

A primary health centre is a paramount institution, and medical officer must be in complete administrative control of the staff.

Services are as good as the personnel giving service. It is, therefore, necessary that medical officers who are the leaders of the health teams, should have high morale. Morale is, however, influenced by various factors, important being security, chances of progress, technically and financially, provision of adequate safeguards to ensure recognition of good and loyal service, fair and just deal, and provision of pension and gratuity to provide and pesnonel. Responsibilities for health of differnt section of minimum living income in old age. The Committee discussed

the various aspects including the pay, service conditions and the process by which unification of cadre can be effected. The Committee drew the attention to the example provided by the Army and by the State Governments of West Bengal, Punjab and Mysore. The details may vary but the greatest common measure of agreement should be in terms of: (a) single portal of entry, (b) common seniority, (c) recognition of extra qualification by provision of ante-date or financial advancement, (d) equal pay for equal work, and (e) special pay for specialised work, special programme, research, teaching, public health and extra hazard.

On private practice the Committee felt that no Government medical officer should normally be allowed private practice. Elimination of private service is, however, beset with many problems, financial and administrative. Judicious and more reasonable procedures would be to eliminate private practice on a phased basis; beginning with teaching or research post health officer, health centre doctor and supervisory posts at the state headquarters and district levels. Compensation for the loss of private practice should however be reasonable.

Appendix I

INTEGRATION OF HEALTH SERVICES

Present position in the States

State	*Are all the officers borne on a unified cadre*	*Are teachers in Medical colleges included in a unified cadre*	*Existence of Intermediate level of health organisation other than the district level*		*Are the curative and preventive health services integrated*			
			Regional Health Organisation	*Sub-divisional Health Organisation*	*at State level*	*at Regional/Zonal/ Circle level*	*Distt. level*	*Sub-divisional level*
1	2	3	4	5	6	7	8	9
Andhra Pradesh . .	No	No	Yes	No	No	No	No (except in 4 Dts.)	No
Assam . . .	Yes	No	Yes	Ye	Yes	Zonal Yes	Yes	Yes
Bihar . . .	No	No	Yes	No	Yes	Yes	Yes	No
Gujarat . . .	No	No	Yes	No	Yes	No	Yes (except for Distt. Hospital & Specialist hospital).	..

1	2	3	4	5	6	7	8	9
Haryana . . .	Yes	(upto Registrars only)	No	No	Yes	..	Yes	No
Kerala . . .	Yes	No	No	No	Yes	No	Yes	No
Madras . . .	No	No	No	No	No	No	No	No
Maharashtra . .	No	No	Yes	No	No	No	No	No
Mysore . . .	UNIFIED	No	No	No	Yes	No	No	No
Madhya Pradesh . .	UNIFIED	Yes	Yes	No	Yes	Yes	Yes	No
Orissa . . .	No	No	Yes	No	Yes	No	No	No (at the block-level—Yes
Punjab . . .	Yes	Yes (upto Registrars only)	No	No	Yes	..	Yes	..
Rajasthan . . .	Yes	..	Yes	No	Yes	No	No	No
Uttar Pradesh . .	No	No	Yes	No	Yes	No	No	No
West Bengal . .	Yes	Yes	No	Yes	Yes	..	Yes	Yes

PAY AND ALLOWANCES OF WEST BENGAL

1. **Designation of the post:**

All Medical Officers belonging to the unified cadre of the West Bengal Health Service are called "Medical Officers" and designated according to the posts held by them.

2. **Classification of the post:**

The unified cadre of the West Bengal Health Service comprises two sectors, *viz.*, (1) Gazetted, and (2) Non-gazetted.

3 **Existing scales of pay :**

(I) *Gazetted*

(a) Basic Grade	Rs. 300—25—800 (E.B. after 8th and 16th stages). Those who are directly recruited as Specialists are given higher initial pay in this grade on the basis of their ante-date calculated according to the Post-graduate qualification and experience possessed by them.
(b) Selection Grade . . . . . (Calculated @8% of the total permanent strength of the cadre.)	Rs. 850—50—1,350
(c) Special Selection Grade . . . . . (Calculated @ 2% of the total permanent strength of the cadre).	Rs. 1,500—60—1,800

II. Non-gazetted

(a) For those possessing M.B.B.S. or M.M.F. qualification :	Rs. 225—10—325—15—475 (E.B. after 10th stage).
(b) For Licentiates	Rs. 200—10—400 (E.B. after 10th stage).

The pay scales mentioned above are the latest scales as last revised under the West Bengal Services (Revision of Pay and Allowance) Rules, 1961 after merging Dearness Allowance in the scales.

In the unified cadre of the West Bengal Health Service there is no specific pay scale attached to a particular post and the Medical Officers of the cadre draw their pay and allowances

according to the grade to which they may belong until such time as they are promoted to the next higher grade according to their seniority and suitability.

The total emoluments comprising pay, special pay and non-practising allowance admissible to a Medical Officer of the unified cadre of the West Bengal Health Service is Rs. 2,100 (Rupees two thousand and one hundred) per month.

4. Non-practising allowance, other concessions, etc.

The service is non-practising but controlled private practice is allowed to the specialist Medical Officers posted in the hospitals at District and Sub-divisional headquarters. Private practice of any kind is not allowed to the Medical Officers of the cadre posted in teaching institutions.

(a) *Non-practising allowance*

(i) *Basic Grade :*	
Upto 5 years' service	Rs. 75 p.m.
Above 5 years' and upto	Rs. 100 p.m.
15 years' service	Rs. 150 p.m.
(ii) Selection Grade	Rs. 200 p.m.
(iii) Special Selection Grade . . .	Rs. 300 p.m.
(iv) Non-gazetted Medical Officers . .	Rs. 40—60—75 p.m. according to length of service.

(b) *Special pay*

Medical Officers not exceeding 25 (twenty-five) per cent of the total cadre constitute a "Specialist Pool" and are given a special pay (treated as special pay) of Rs. 50 per month provided they possess recognized post-graduate qualifications and/or experienced in particular subjects.

(c) *Teaching allowance (treated as Special pay)*

(i) Director-Professors, Professor Associate Professors	Rs. 100 p.m.
(ii) Readers, Assistant Professors . . .	Rs. 75 p.m.
(iii) Lecturers, Demonstrators, Clinical Tutors	Rs. 50 p.m.

(d) *Public Health pay (treated as Special pay).*

Medical Officers posted for public health duties are given a Special pay @ Rs. 50 per month each.

(e) *Administrative pay (treated as Special pay)*

Medical Officers holding administrative posts in the Selection Grade or in the Special Selection Grade are also given Administrative pay ranging from Rs. 100 to Rs. 250 per month as indicated below:

(i) Director of Health Service . . .	Rs. 250 p.m.
(ii) Principals of Medical Colleges, Dy. Directors of Health Services and Superintendents or Heads of large hospitals or institutions as well as similar other posts involving administrative functions of equivalent magnitude	Rs. 150 p.m.
(iii) Asstt. Directors of Health Services, Chief Medical Officers of Health Directors of different departments of teaching institutions and superintendents of hospitals or institutions as well as similar other posts involving administrative functions of equivalent magnitude.	Rs. 100 p.m.

(f) *House Rent Allowance*

Medical Officers posted in Health Centres, Clinics or other institutions in areas outside the headquarters of Districts and sub-divisions are given free unfurnished quarters or actual house rent in lieu thereof subject to a maximum of 20 per cent of their pay including special pay, if any.

Those who are debarred from private practice and are posted in Calcutta area are also eligible for house rent allowance as admissible to the State employees of other categories.

Normally only one of the special pays mentioned in items (b), (c) and (e) above is admissible to a Medical Officer at a time, *i.e.*, not more than one special pay can be drawn simultaneously.

GIPN—S 8—7 D. G. H. S. (N.D.)/67—25-7-68—1500